United Nations A/65/PV.91

General Assembly
Sixty-fifth session

Official Records

91st plenary meeting
Wednesday, 8 June 2011, 3 p.m.
New York

President: Mr. Deiss ..... (Switzerland)

The meeting was called to order at 3.05 p.m.

Agenda item 10 (*continued*)

Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

High-level Meeting on the comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Report of the Secretary-General (A/65/797)

The President (*spoke in French*): I would like to thank delegations in advance for maintaining silence during the debate. I also remind them that, pursuant to the relevant resolution, statements are limited to five minutes. I would therefore ask speakers to observe the time indicator that is on the speaker's rostrum.

The Assembly will now hear an address by His Excellency The Honourable Mr. Denzil Douglas, Prime Minister and Minister of Finance of Saint Kitts and Nevis.

Mr. Douglas (Saint Kitts and Nevis): I speak before the General Assembly on behalf of the member States of the Caribbean Community (CARICOM) in my capacity as the lead CARICOM head of Government with responsibility for human resource development, health and HIV/AIDS. I am also speaking on behalf of that wider Caribbean constituency, the Pan-Caribbean Partnership against HIV/AIDS (PANCAP), which I have the honour to chair.

Some 10 years ago when countries gathered here in New York for the special session of the General Assembly on HIV/AIDS, it was amid great uncertainty about how and what had to be done to stem the tide of this pernicious disease, which seemed to strike the death knell for those infected and brought anguish to those affected. That conference resolved to take certain bold steps, including the establishment of what is now called the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 10 years, collective action and an increasing level of shared responsibility have given hope that better must come to people living with HIV and AIDS.

Through the dedicated work of natural and behavioural scientists, philanthropists and non-governmental organizations (NGOs), as well as leadership at the national and global levels, great strides have been made. Scientific research has produced medicines, in particular generic medications to aid care and treatment. The application of behaviour change through social marketing interventions has contributed in no small measure to arresting the spread of HIV, reducing the number of deaths from HIV and AIDS and increasing awareness of prevention policies. In so doing, there is a growing realization of the need for inclusiveness aimed at the eradication of HIV-related stigma and at enabling equitable access to HIV-related information and services, especially for the most at-risk populations.

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The membership of CARICOM and PANCAP has always played a very active role in this global process for an accelerated approach to the issue of HIV. It is no doubt in our self-interest to find solutions, since our region remains second only to sub-Saharan Africa in terms of prevalence rate. Nevertheless, the Caribbean holds out the prospect of being among the first group of countries in the world to achieve universal access.

It is worth reminding this body that it was the Caribbean Community that responded immediately to the 2001 Declaration of Commitment on HIV/AIDS. Just two weeks later, on 2 July 2001, at its Conference of Heads of Government, it was stated, through the Nassau Declaration, that the health of the region was the wealth of the region. The Conference identified the Pan Caribbean Partnership against HIV and AIDS as one of the main pillars and aligned its actionable recommendations with the outcomes of the Declaration of Commitment. The other pillar, the Caribbean Cooperation in Health, is a broad framework that outlines major priorities in public health and includes HIV as one of its action areas.

In that context, the most recent initiative, the establishment of the Caribbean Public Health Agency, through the consolidation of five regional health institutions, is the ultimate manifestation of the Nassau Declaration. This consolidation may yet act as a catalyst for the realization of both universal access and the achievement of the health and HIV/AIDS indicators of the Millennium Development Goals by the 2015 target date.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) scorecard on universal access in 2010 demonstrates that much progress has been made in the Caribbean region. Over the past 10 years, the prevalence rate has stabilized at 1 per cent overall, with significant variations among countries. New HIV infections have declined by 14 per cent. AIDS-related deaths have also declined by some 43 per cent. The Caribbean was the first region in the world to submit all of its national reports to the General Assembly by the stipulated date.

Efforts to reduce stigma and discrimination have intensified. Programmes in that connection target the formal education sector, youth, the workplace and faith-based organizations, among others. The engagement of our universities, other regional institutions, NGOs and the media has also provided an impetus for an accelerated approach to HIV and AIDS.

In this regard, therefore, as we meet today, there is much to celebrate within the Caribbean region. Yet for us in the Caribbean, warning signals remain. An estimated 17,000 persons were newly infected with HIV in 2009. Indications are that transmission rates among key populations, such as men who have sex with men, are increasing. In addition, unprotected sex between men and women — especially sex workers — is believed to be the main mode of HIV transmission, making the Caribbean the only region besides sub-Saharan Africa where women and girls outnumber men and boys among people living with HIV. In 2009, an estimated 53 per cent of people with HIV were female. High infection levels have been found among female sex workers — including 4 per cent in the Dominican Republic, 9 per cent in Jamaica and 27 per cent in Guyana. Consequently, most countries in the region have targeted those groups for HIV prevention.

We in the Caribbean have come to recognize that while progress has been made, the gains will be fragile unless innovative and bold steps are taken towards the goal of an HIV-free generation. Hence today we join in the chorus in the Assembly calling for a strong impetus at all levels towards achieving universal access to HIV prevention, treatment, care and support. We support the recommendations of the Secretary-General contained in his report (A/65/797), which focus on prevention, on revitalizing the push for universal access and on striving for value for investment through enhancing access to essential medicines and maximizing efficiency in terms of non-drug-related costs. In this regard, particular attention must be paid to women and girls, with an emphasis on reversing harmful gender norms.

In the final analysis, ambitious national targets must be set and emphasis placed on achieving accountability standards. The outcome document of this High-level Meeting will set laudable targets for the future, but they will not be achieved unless the Assembly also endorses a global compact based on shared responsibility, creative and collective leadership, broad national ownership, the innovative use of technology and the engaging of communities, including through the increased use of social media to develop local and sustainable solutions.

We in the Caribbean believe that emphasis must also be placed on securing long-term, sustainable financing, without which a reversal of the marginal gains made over the past 10 years is inevitable. We in the Caribbean support the need for replenishments, so that the Global Fund can be maintained and increased. We also support the need to harmonize donor resources so as to reduce the administrative burden. We in the Caribbean will continue to advocate for a revision of the conditionalities that impose increased burdens on small economies designated as middle-income countries without taking proper account of their vulnerabilities. However, we will equally support the call for the proper management of financial resources and for policies that ensure that people living with HIV are placed at the centre of our concerns.

We commend the Global Plan of the UNAIDS Global Task Team, chaired by Michel Sidibé and Ambassador Goosby, aimed at the elimination of new HIV infections among children by 2015 and at keeping their mothers alive. The recommendations in this plan make the call for such elimination a standard refrain. Let us take our cue from this positive approach.

We in the Caribbean, at the tenth Annual General Meeting of the Pan Caribbean Partnership, held in Saint Maarten in November 2010, identified specific deliverables for our region by 2015. Those are the elimination of mother-to-child transmission; the elimination of travel restrictions for people living with HIV; an 80 per cent increase in access to treatment; a 50 per cent reduction in infections; and the acceleration of the agenda to address prevention, care and treatment. These are all aligned with the Millennium Development Goals, whose 2015 deadline must act as an incentive. This global partnership must work collectively to achieve the targets that we all support in the interest of humanity, those living with the disease and those yet to be born.

The President (*spoke in French*): I wish to remind speakers that statements are limited to five minutes for statements made in national capacities, and eight minutes made on behalf of a group. I ask speakers once again to observe the time indicator that is on the speaker's rostrum.

The Assembly will now hear an address by His Excellency Mr. Aires Bonifacio Baptista Ali, Prime Minister of the Republic of Mozambique.

Mr. Ali (Mozambique): At the outset, allow me to join previous speakers in congratulating the United Nations for having organized this important event. This High-level Meeting constitutes a historic opportunity for us as nations and multilateral institutions to reaffirm our role in, and commitment to, addressing the threat posed by HIV and AIDS to our development agenda as we strive to achieve the targets agreed for 2015.

We are encouraged by the results contained in the report of the Secretary-General before us (A/65/797), which indicate that our efforts to address the scourge of the HIV pandemic at the global, regional and national levels have yielded encouraging outcomes. Nevertheless, the challenges before us are still overwhelming. We are confident that this meeting will lead to a commitment, based on the valuable knowledge that we have amassed over the past three decades, that will deliver on the greatly aspired-to goal of universal access.

The General Assembly Declaration of Commitment on HIV/AIDS (resolution S-26/2) remains the guide for our national AIDS response in implementing the "three ones" principles. Mozambique is now implementing its third national strategic plan on HIV, for the period 2010 to 2014, within a decentralized framework focused on reducing new infections. The presidential initiative on HIV and AIDS launched in February 2006 accelerated, and continues to give impetus to, national efforts carried out in a coordinated way by all sectors — public, private, civil society and the media.

As a result of a consistent national strategy and strong support from our bilateral and multilateral partners, Mozambique has been able to reach historic levels of service delivery and outreach, namely, in increasing access to antiretroviral treatment, including for children under 15 years of age, and services for the prevention of mother-to-child transmission. The promotion of support and services to protect orphans and vulnerable children through families and community-based organizations also deserve special attention.

Our first-ever national HIV survey, which was carried out in 2009, points to the fact that women, and in particular young girls, are the most vulnerable to HIV infection. Hence, over recent years, reducing vulnerability and risks, including ways of dealing with

stigma, gender inequality and gender-based violence, has received increased attention in national efforts.

Mozambique is strongly committed to the elimination of mother-to-child transmission by 2015. In that regard, a robust national plan of action will be implemented. Mozambique will certainly achieve the virtual elimination of mother-to-child transmission as recommended by the African Union Summit in Kampala in July 2010.

The integration of HIV and AIDS and other health services has proved beneficial in terms of highly improved access to HIV related treatment and care as well as tuberculosis and other health services.

The importance of many sectors, including social affairs, education, youth and agriculture, is highly visible in both the prevention of HIV and the mitigation of the negative impact of AIDS. Greater youth involvement is part of our national strategy.

In conclusion, we would like to emphasize that our national efforts must be driven by the evidence, which indicates that prevention will continue to be our leading priority in our fight against HIV and AIDS. The low levels of condom use and HIV testing remain urgent challenges, and the feasibility of the general promotion of male circumcision will need further assessment. The strengthening of the health system should also put emphasis on maternal and child health, both from the clinical point of view as well as from the perspective of community participation and support for social services.

We call for continued and increased national and international commitment and solidarity in facing the very real threat that AIDS poses to our nations.

The President (*spoke in French*): The Assembly will now hear an address by His Excellency Mr. Mohamed Gharib Bilal, Vice-President of the United Republic of Tanzania.

Mr. Bilal (United Republic of Tanzania): Allow me to congratulate you, Mr. President, and the United Nations for having organized this High-level Meeting on HIV and AIDS, which is once again bringing the issue of HIV and AIDS to the global stage. We thank the Secretary-General for his report entitled "Uniting for universal access: towards zero new infections, zero discrimination and zero AIDS-related deaths" (A/65/797). The recommendations provided in that report warrant our serious consideration.

We commend the work undertaken by the secretariat and of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its co-sponsoring agencies in the implementation of the Declaration of Commitment on HIV/AIDS (resolution S-26/2) and the Political Declaration on HIV/AIDS (resolution 60/262). We also welcome the Secretary-General's Global Strategy for Women's and Children's Health, which aims at reducing the number of maternal, newborn and under-five deaths.

Tanzanians live with the devastating impact of the virus on a day-to-day basis. The socio-economic impact of the HIV and AIDS epidemic in a poor country like Tanzania is enormous. Among the effects of the epidemic that are felt most is the growth in the number of orphans and vulnerable people, currently estimated at about 1 million.

The Government of the United Republic of Tanzania and the Revolutionary Government of Zanzibar have continued to implement both the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS. A strong political commitment on the part of the President himself, and the entire Government, has enabled the country to achieve progress in combating HIV/AIDS. To encourage voluntary counselling and testing, which are key factors in the prevention and treatment of HIV and AIDS, in mid-2007 the President and the First Lady of the United Republic of Tanzania initiated a testing campaign and shared their own test results. At the time, close to 2 million people had been tested, but by December 2010 the number had grown to 13 million. That action, coupled with the increase in the use of condoms and antiretrovirals, a programme on the prevention of mother-to-child transmission and a high information, education and communication uptake, has enabled us to see the beginning of a decline in the HIV prevalence rates from 7 per cent to 5.7 per cent in mainland Tanzania, while in Zanzibar the prevalence rate is below 1 per cent.

Our Government has put in place modalities for expanding coverage and sustaining treatment services through its 2008 health policies: the Health Sector Strategic Plan III; the Maternal, Newborn and Child Health I plan; the 2008 National Multisectoral Framework; and the 2008 Health Sector HIV/AIDS Strategic Plan. We are also using the decentralized health system, as per our Primary Health Care Development Programme, to expand treatment to more

primary and community-based facilities. Through these actions, the number of people on antiretrovirals had reached 388,000 by December 2010. In 2010, antiretrovirals were being provided to 70 per cent of HIV-infected pregnant women and 57 per cent of HIV-exposed babies.

On the prevention front, the Tanzanian Government has put in place various HIV prevention methods, including male circumcision and the control and treatment of opportunistic diseases, as well as early detection and treatment of other high-risk diseases for HIV/AIDS transmission, including tuberculosis and sexually transmitted infections.

Combating HIV and AIDS is everyone's responsibility. At this juncture, I would like to underscore the importance of involving the private sector and civil society in this endeavour. We wish to acknowledge the support of our development partners, both bilateral and multilateral, as well as of the private sector and social entrepreneurs. The Government, for its part, has provided an enabling environment that includes HIV/AIDS policy and legislation, and has mainstreamed HIV/AIDS into its national development strategy to ensure that more funds are available from the Government budget.

Tanzania faces a number of challenges that may threaten our achievement of some of our national and Millennium Development Goals and targets. These include dealing with the stigma of HIV/AIDS as well as the financing gap for HIV and AIDS intervention, which is above 90 per cent. To that end, Tanzania is establishing an AIDS trust fund and putting in place modalities to scale up the national health insurance fund and community health funds to work towards universal coverage. This will help to further build national capacity to meet the growing resources required for prevention, treatment and care, mitigation, and building an enabling environment that can help us meet all the needs of the Tanzanian community.

Mr. Ould Hadrami (Mauritania), Vice-President, took the Chair.

It is also unfortunate that people die prematurely from AIDS because, inter alia, poor nutrition exacerbates the impact of HIV on the immune system and compromises its ability to respond to opportunistic infections. That is why we urge immediate action at the national and global levels on integrating agricultural, food and nutritional support into programmes directed at people affected by HIV. This is in order to ensure access to sufficient, safe and nutritious food that can enable people to meet their dietary needs and food preferences for an active and healthy life, as part of a comprehensive response to HIV and AIDS.

The Tanzanian Government will continue to do its part and to participate in many of the initiatives towards zero new infections, zero discrimination and zero AIDS-related deaths. We once again urge the international community to complement and supplement our national efforts and to continue to invest in HIV and AIDS prevention, treatment, care and support.

The Acting President: The Assembly will now hear an address by His Excellency Mr. Richard Kamwi, Minister of Health and Social Services of Namibia.

Mr. Kamwi (Namibia): I have the honour to speak on behalf of the 14 States members of the Southern African Development Community (SADC). SADC aligns itself with the statement made by the representative of Senegal on behalf of the African Group.

The SADC group wishes to assure the Assembly of its full support and cooperation for a successful conclusion of this crucial gathering. This is a pivotal time, when the whole world has come together to take stock of the progress made in the global response to the HIV and AIDS pandemic and to craft a way forward. We will be judged not on looking back, but rather on the quality and success of the plans we forge for the future global response to the epidemic over the coming decades.

When I speak for SADC I also speak for the estimated 11 million people living with HIV in our region — a reality that can be expressed in dry figures, as well as through the suffering of the people, communities and nations in our region that have been devastatingly affected by the world's largest-ever epidemic. I declare, on behalf of the leaders of SADC, that as leaders we will continue to lead and will forge the regional response to the HIV and AIDS epidemic, guided by the Maseru Declaration on HIV and AIDS, until we reach the elimination of new infections. The level of commitment I see here today gives me great confidence that we will do so. The world is not merely meeting just to launch yet another plan or declaration on how to tackle this persisting challenge, but is celebrating the unwavering commitment of

Governments, partners, donors, the international community, non-governmental organizations, community-based associations and communities to make a tremendous difference in the lives of our peoples.

Progress has been made in fighting the AIDS epidemic in our region. The percentage of adults living with HIV has fallen by up to 25 per cent in the most affected countries. Most of our countries now have prevention of mother-to-child transmission coverage rates of greater than 70 per cent, and three have managed to reach 90 per cent. However, we must stay vigilant. The progress that has been made remains very fragile and must not be allowed to slide back.

We are deeply concerned that the number of newly infected people still outstrips the number of people starting treatment. The 2 million-plus people on treatment must be weighed against the 3 million who require treatment now but do not have access. Moreover, it is imperative to act in response to the new, groundbreaking results from the research that shows that treatment can reduce HIV transmission between couples by 96 per cent. That means we have a much bigger reason to provide antiretrovirals to many more of those who need it.

We must also be aware that most of the resources used for the AIDS response come from outside our region. The sustainability of those funds is threatened by the global financial crisis and changing donor priorities, meaning that we as SADC countries are obligated to find tangible solutions to our priority issues.

The biggest challenge we face as a region is to keep the necessary resources flowing for the AIDS response. We have pledged once again to increase national health budgets towards the 15 per cent Abuja target of African Union member States, and we will explore various innovative strategies aimed at mobilizing domestic resources, such as Zimbabwe's AIDS levy, which is collected from all workers' salaries every month.

SADC countries are encouraged to create a core strategic financial plan for the health sector to guide Governments and partners. We recommit ourselves to making efficient and effective use of resources and to being accountable. However, without international solidarity and external support, our AIDS response will be significantly undermined.

For the benefit of all those who have been affected by the epidemic, putting an end to it is uppermost in our minds. We therefore request continued, increased, predictable and sustainable financial assistance, through international mechanisms such as the Global Fund, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and other sources of funding.

We call for the full replenishment of the Global Fund and for appropriate reform of its governance to improve accountability. We ask for technical support for our local capacities to develop and generate the data that will tell us where to spend our resources in order to make the greatest impact, and how to improve ways of measuring our success. We continue to call for the invigoration of research towards finding a cure for HIV and AIDS.

Let me end by reiterating a fundamental fact that is of great concern to our region. If the AIDS epidemic is not controlled and sustainably well resourced in southern Africa, global targets under Millennium Development Goal 6 and the other related Goals will not be met.

I thank the Secretary-General, Mr. Ban Ki-moon, for his stewardship of the United Nations Secretariat. I also thank the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Michel Sidibé, and all other key relevant stakeholders. Their leadership in the context of this global response is needed to improve the lives of the peoples of the world. We, the SADC member States, are committed to playing our part to the best of our abilities.

I shall now make a statement in my national capacity.

Namibia aligns itself with the statement of the Southern Africa Development Community (SADC), which I have just delivered, and that made by Senegal on behalf of the Group of African States.

We are 30 years into the HIV/AIDS pandemic, and it has been 25 years since my country, the Republic of Namibia, experienced its first confirmed case of AIDS. Thus there is good reason for the international community to pause and to review the progress made to date and to ponder emerging challenges. Namibia has actively participated in the global review process and has hosted and chaired a number of important events that have added value to this High-level

Meeting. That includes hosting a recent visit to Namibia by Mr. Michel Sidibé, Executive Director of UNAIDS, and chairing the fifth session of the African Union Conference of Ministers of Health in our capital city, Windhoek, in April 2011.

At the conference, Africa's common position in this High-level Meeting was debated and agreed upon. We are grateful to be able to report that great progress has been made in our national fight against HIV/AIDS, especially with regard to the provision of lifesaving treatment for both adults and children living with HIV.

Namibia has benefited over the past decade from significant donors, especially the Global Fund to Fight AIDS, Tuberculosis and Malaria; PEPFAR; and technical support from the United Nations towards an HIV response. That support, which commenced as a direct response to the 2001 Declaration of Commitment on HIV/AIDS, has been critical to the important scale-up of resources and the formation of a recognized national movement aimed at assessing, analysing and proactively responding to the challenges posed by the epidemic in Namibia's national context.

As a result, we have exceeded our 2010 universal access targets for antiretroviral therapy and the prevention of mother-to-child transmission. We have also ensured our ability to continue increasing national funding, in order to cover close to 50 per cent of the national response from domestic resources. We are actively working to maintain or even increase that level.

Namibia is now dealing with the latest challenges in our national HIV/AIDS response. Our focus is on ensuring zero new HIV infections, zero discrimination and zero AIDS-related deaths. That means that prevention must and will become the priority in our national response. Furthermore, enhanced scale-up, assured quality and improved adherence will be the fulcrum of treatment and the reduction of stigma and discrimination, and the promotion of human rights will be paramount. At the same time, it is incumbent on us to enhance efficiencies and productivity through integration of our efforts, strengthened alliances and partnerships and a renewed focus on innovation.

At the launch of Namibia's new national strategic framework for HIV/AIDS for the period 2011-2016, my President, His Excellency Mr. Hifikepunye Pohamba, called on stakeholders to work together, coordinate our efforts and create synergies among the actions of different sectors of society. Indeed, we must continue to intervene quickly, systematically and decisively in order to intensify our interventions at the policy and service-delivery levels. Sustainability and taking increasing ownership will be at the core of our response over the coming five years.

Nevertheless, we will continue to rely on international, regional and local partnerships, cooperation and solidarity. Namibia believes that this 2011 High-level Meeting of the General Assembly on HIV/AIDS is an excellent opportunity for the world to join hands and take coordinated and reinvigorated steps to ensure that we overcome the new challenges posed by the HIV/AIDS pandemic. My country, Namibia, stands ready to engage in game-changing, win-win undertakings in that regard.

The Acting President: I now give the floor to Mr. Edgar Giménez, Vice-Minister of Public Health of Paraguay, who will speak on behalf of the Union of South American Nations.

Mr. Giménez (Paraguay) (*spoke in Spanish*): The countries members of the Union of South American Nations (UNASUR) have a very similar epidemiological profile. HIV prevalence is highest in specific groups that historically have suffered from stigma and discrimination. Those groups, however, are key elements in controlling the epidemic.

Men who have sex with men, male and female sex workers, injecting and other drug users are the groups that have been most affected by AIDS in Latin America since the emergence of the first few cases. In that respect, coordination among Governments, civil society groups and communities is the means that our countries use to fight this public health problem.

The link with the promotion and protection of the human rights of those living with HIV forms the basis of our response and makes clear that HIV/AIDS is a problem that extends well beyond the health sector. The epidemic affects the development of our societies and our countries. We must therefore think of health as a human right and for that reason promoting access is a fundamental commitment for our Governments. In that spirit, we members of UNASUR Salud are here today to reaffirm our commitment to eliminating barriers to access to the prevention, treatment and support needed by people living with HIV.

The cost of drugs, reagents and other supplies is one of the biggest threats to the right to health in our countries. The countries of our region are ranked medium- and high-income countries, but such assessments do not take into account the inequalities that sadly still exist in our societies. That makes it difficult to negotiate fair prices for drugs, especially antiretrovirals and reagents.

Even more importantly, however, in our quest for universal access we could make full use of the flexibility offered by the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights and of an effective implementation of the World Health Organization's Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and its Global Health Sector Strategy for HIV/AIDS, 2011-2015. That would allow countries to fulfil their commitment to responding to the epidemic based on a view of health as a human right. To that end, we call for greater support from United Nations agencies.

The UNASUR countries are ready to bolster our action to tackle this epidemic, seeking universal access to prevention and comprehensive care for people living with HIV, as well as access to all complementary care, equitably and without discrimination of any kind.

The Acting President: I now give the floor to His Excellency Mr. Seren Pind, Minister for Development Cooperation and Minister for Refugee, Immigration and Integration Affairs of Denmark.

Mr. Pind (Denmark): The Secretary-General has underlined it in his report (A/65/797), the report of the Joint United Nations Programme on HIV/AIDS emphasizes it, and so have several speakers before me: We need a rights-based approach to HIV/AIDS prevention, treatment and care. And we need to ensure that legal, social and political environments do not hamper an effective HIV/AIDS response.

Allow me to be even more outspoken and direct. We can provide more condoms, we can improve communication and information and we can increase access to treatment, but we will not be able to tackle the HIV epidemic efficiently as long as we do not also squarely address stigma, discrimination and violations of human rights.

Some countries find it difficult and uncomfortable to talk about human abuse of sexuality in a public health context. We often shy away from talking about what is after all a natural part of being a human being. If we are serious about fighting HIV/AIDS and if we are serious about creating an AIDS-free generation for our children and grandchildren, we need to face the reality of human sexuality. HIV is, after all, mainly spread through sexual contact.

We need to accept that men who have sex with men, sex workers and drug users are among the hardest hit in many countries. If we meet those groups with discrimination and stigma and if we violate their human rights, we will help no one. By depriving them of relevant information, counselling and testing or by not providing them access to condoms and treatment we will only fuel the epidemic further.

That is why we, in our fight against HIV and AIDS, have chosen to strengthen our efforts against stigma and discrimination. That is why the promotion of human rights is key to our approach. It was also one of several recommendations put forward after a recent review of Denmark's support to the fight against HIV/AIDS. The review focuses on Denmark's response to HIV/AIDS from 2005 to 2010. During that time, Denmark doubled its support to fighting HIV/AIDS from 500 million to 1 billion Danish kroner annually. Today, our HIV/AIDS support amounts to approximately 8 per cent of Danish official development assistance. The review will guide our approach in the years to come.

Overall, the review is very positive. It shows that the priorities in the strategy for Denmark's support to the international fight against HIV/AIDS have been and still are relevant in addressing this threat to the health and livelihoods of so many people in the developing world. It confirms our multi-sector approach whereby the combat against HIV/AIDS has been mainstreamed into all other programmes.

But looking ahead, the review also points to areas where Denmark can increase its impact on the HIV/AIDS response and use the 1 billion Danish kroner more efficiently. In light of our experience and taking the recent epidemic trends into account, we will put more emphasis on ensuring the supply and more efficient distribution of male and female condoms in Africa. The Global Programme to Enhance Reproductive Health Commodity Security of the United Nations Population Fund does a very important job in this field and deserves our encouragement and

support. Denmark will also increase its support to preventing vertical HIV transmission from mother to child by increasing access to treatment and by improving the quality of services. In doing so, we will be particularly mindful of the important link between combating HIV/AIDS and ensuring sexual and reproductive health and rights.

Denmark will increase its support to the development of innovative technologies. Vaccine development is a high-risk but also a high-return investment. No viral infectious agent has ever been brought under control until a vaccine was developed. Denmark will support those organizations that can identify and efficiently develop the most promising AIDS vaccine candidates.

We will also increase our support to the most-at-risk populations. We will do so through organizations that can provide information, testing, treatment and care directly to those groups in their local communities and thus can make a difference on the ground. I urge others to join us in this effort.

Finally, we remain committed to supporting strong national health systems. We must address prevention and treatment in a way that includes all population groups. We have seen that political leadership and national ownership are key ingredients to those ends.

The challenges that we face are still immense, but based on our lessons learned and on new knowledge and technology, the prospects for prevailing are better than ever. This requires that we use our resources even better. Denmark remains fully committed to fighting HIV/AIDS. It is a fight we must not lose. It is a fight we will not lose.

The Acting President: The Assembly will now hear an address by His Excellency Mr. Truong Vinh Trong, Deputy Prime Minister of Viet Nam.

Mr. Truong Vinh Trong (Viet Nam) (*spoke in Vietnamese; English text provided by the delegation*): Viet Nam welcomes the convening of the 2011 High-level Meeting on HIV/AIDS. This meeting is of great importance as the world marks 30 years of the AIDS epidemic and 10 years of implementation of the Declaration of Commitment on HIV/AIDS (resolution S-26/2).

Since the General Assembly's landmark twenty-sixth special session on HIV/AIDS in 2001, the global response to the pandemic has recorded significant outcomes. The number of newly-infected people has decreased by 19 per cent over the past decade; access to antiretroviral therapy has expanded; stigma and discrimination have decreased; and the rights of people living with HIV/AIDS have gained greater respect.

On behalf of the Government and people of Viet Nam, I salute these encouraging accomplishments, which could not have been possible without the tireless efforts of the United Nations under the leadership of the President of the General Assembly, the Secretary-General and the Joint United Nations Programme on HIV/AIDS (UNAIDS). They are also attributable to the active responses of leaders of Member States and many international organizations and eminent persons.

By 2010, Viet Nam had achieved many Millennium Development Goals ahead of schedule, including those on poverty reduction, the universalization of education, the promotion of gender equality and the improvement of maternal and child health, which has been widely recognized by the international community. As to HIV/AIDS prevention and control, with about 0.26 per cent of the population currently HIV-infected, Viet Nam has been able to contain the rise of infection. In concrete terms, the rate of HIV prevalence among injecting drug users declined from 30 per cent in 2001 and 2002 to 17 per cent in 2010, while the number of HIV/AIDS-related deaths has declined from more than 6,000 a year to some 2,500 a year for the past two years, to cite just two statistics.

Extensive AIDS-awareness campaigns have been conducted frequently throughout Viet Nam over the past 20 years. The enactment of a law on the prevention and control of HIV/AIDS and many other related legal documents has helped to encourage and facilitate the greater participation of the population and social organizations. The national strategy on HIV/AIDS prevention and control has been developed and organically integrated into the country's socio-economic development strategy. The National Committee on HIV/AIDS, Drugs and Prostitution Prevention and Control, founded over 10 years ago, has effectively strengthened the coordination of efforts among different agencies and people of all social strata so as to ensure the implementation of HIV/AIDS response measures in tandem with measures to combat drugs and prostitution. Viet Nam's experience shows that the prevention and control of HIV/AIDS, drugs and

prostitution should be aligned with efforts to reduce poverty, raise social awareness and knowledge, improve health care and promote gender equality.

In this connection, the Government and people of Viet Nam highly value the meaningful support and effective cooperation extended to Viet Nam's HIV/AIDS prevention and control efforts in recent years by the United Nations, most directly through UNAIDS; co-sponsors such as UNICEF, the United Nations Development Programme, the United Nations Population Fund, the International Labour Organization, UNESCO, the World Health Organization and the World Bank; and other international organizations, especially the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief; as well as many countries and international friends.

Despite its tremendous accomplishments in national development, Viet Nam remains a poor country faced with numerous difficulties. The Vietnamese Government is fully aware that the initial gains achieved in our national response remain fragile. Viet Nam has embarked on developing the next phase of the national strategy for HIV/AIDS prevention and control, which is an essential component of our efforts to promote sustainable social and economic development for 2011-2015.

To that end, resources will be prioritized for the implementation of national targets on HIV/AIDS, as well as the international goal of universal access to HIV/AIDS prevention, care, treatment and support and the latest United Nations initiative on zero new HIV infections, zero discrimination and zero AIDS-related deaths. The Government and people of Viet Nam are strongly committed to these goals. At the same time, we look forward to the continued support and close and effective collaboration of the United Nations system, Member States and international organizations in this endeavour.

The AIDS epidemic remains a major global challenge and a threat to the sustainable development of many nations. It can be averted only by the joint efforts and shared responsibility of each and every member of the international community. Viet Nam endorses the Secretary-General's report (S/2011/797) on the implementation of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS (resolution 60/262). We support the draft outcome document to be adopted at this High-level Meeting and at the same time underline the following.

First, in the context of daunting challenges to global development, the international community must sustain its constant state of alert to the HIV/AIDS problem and secure the resources needed for national and international HIV/AIDS responses. While those challenges are common, HIV and AIDS represent the most formidable challenge to poor developing countries. The fight against HIV/AIDS should therefore receive special attention and support from the international community.

Secondly, prevention is the best cure. This is particularly relevant to HIV/AIDS. Hence, undertaking comprehensive preventive measures is imperative. These may include education, communication and awareness-raising, especially among young people. Harm reduction interventions, counselling and the improvement of diagnostic capacity are also essential to efforts towards the goal of zero new infections. This requires the strong involvement of people of all walks of life and social segments, as well as the leadership of Governments.

Thirdly, people living with HIV/AIDS must have better access to health care services, including and especially antiretroviral therapy and methadone treatments. We need to facilitate the production of low-cost antiretroviral therapy and methadone through technology transfer and financing for developing countries. At the same time, importance should be attached to early detection and continuous treatment for HIV-infected people.

I wish the Meeting great success. May the President and all present enjoy an abundance of health.

The Acting President: The Assembly will now hear an address by Her Excellency Ms. Susan Rice, member of the Cabinet of the President of the United States of America.

Ms. Rice (United States of America): I am honoured to represent the United States at this High-level Meeting on HIV/AIDS.

Today, 30 years after the United States Centers for Disease Control and Prevention first reported on the condition that would eventually become known as HIV, the world has proven that we can tackle this pandemic. But going forward, all of us must do more.

We call today on our fellow donors and partners — great and small — to increase their investments and to redouble their commitment.

We do so because the history of the pandemic shows how much we can accomplish when we stand together. In 2001, when the General Assembly held its special session, the global HIV/AIDS situation was grave. From 1981 to 2001, nearly 58 million people worldwide were infected. More than 25 million people died. Health systems buckled under the weight of the pandemic.

The American people were moved by that sweeping tragedy, and we urged the international community to come together in a spirit of compassion and concern. The General Assembly's 2001 special session on HIV/AIDS underscored our shared responsibility to respond.

My Government is proud to have long been a leader in this global fight. The United States played a central role in establishing the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2002, the United States made the founding pledge to the Global Fund, and today we are proud to remain by far its largest single donor. We made our first-ever multi-year pledge to the Global Fund this year, and we are working closely with the Fund on a robust reform agenda that will let it save even more lives.

In 2003, the United States created the President's Emergency Plan for AIDS Relief, known as PEPFAR, the largest international response to a single disease that any country has ever mounted. When PEPFAR was launched, fewer than 50,000 people in all sub-Saharan Africa had access to treatment. By September 2010, PEPFAR had supported treatment for more than 3.2 million people, the vast majority of them in Africa.

Today, more than 3.8 million orphans and vulnerable children also receive support from PEPFAR that gives them education, nutrition and the chance of a better life. One particular focus of the United States efforts has been the reduction in the mother-to-child transmission of HIV. In 2010, programmes supported by PEPFAR provided HIV counselling and testing to more than 8.6 million pregnant women. More than 600,000 of them tested positive for HIV and received antiretroviral drugs to prevent mother-to-child transmission, thereby saving about 114,000 babies from HIV infection.

So, today, let us renew our common commitment to achieve a generation free of HIV. The United States also remains committed to responding to the serious HIV epidemic that we face here at home. In all, more than 1.7 million Americans have become infected with HIV. More than 600,000 have died of AIDS, and more than 50,000 people become infected with HIV each year.

In July 2010, the United States released the first comprehensive National HIV/AIDS Strategy for the United States to provide a road map for reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities.

We remain proud that the United States currently provides about 58 per cent of all donor-Government resources to respond to the global HIV/AIDS pandemic. That stems from an abiding commitment. President Bush launched PEPFAR, and President Obama has ramped it up and combined it with other programmes under the United States Global Health Initiative. That means that we get better overall health outcomes as we tackle HIV and better AIDS outcomes as we tackle maternal and child health, neglected tropical diseases and other crucial dimensions of global public health. The United States has long been a leader in saving lives and restoring hope, and we will not let up now.

But the global HIV/AIDS challenge cannot be met by any one country alone. AIDS is truly a global crisis, and it requires a truly global response. Today, we urge our fellow donors and the private sector to do more, to give more and to invest more. To sustain the fight over the long term, affected countries themselves must provide the resources, based on their economic capacities, to protect their citizens from HIV/AIDS. Other donor countries must also increase their commitment to the fight, as, again, must the private sector.

At the same time, we should take a moment today to salute the champions of the fight against HIV/AIDS in the worst-affected countries — Governments that have risen to defend their citizens, communities that have rallied around those in need, and civil society groups and individuals whose activism and simple decency have offered hope and comfort in hours of grief and fear. They are the unsung heroes of this

battle. The best way we can honour them and their dedication is to join together in redoubling our fight.

We must do more than maintain the gains that we have made. We must expand on them. Too many people are counting on us. Too many lives can and must still be saved. The declaration that we will adopt at this Meeting reflects a strong and shared commitment. We urge all our fellow Member States to join in giving that commitment greater meaning and power, to come together, to lead and to rise to this grave and urgent challenge.

The Acting President: I now give the floor to His Excellency Mr. Abdelkader Messahel, Minister for Maghrebian and African Affairs of Algeria.

Mr. Messahel (Algeria) (*spoke in French*): Coming 10 years after our Assembly's adoption of the Declaration of Commitment on HIV/AIDS (resolution S-26/2), our High-level Meeting is an important gathering. It provides us with the opportunity to take stock of progress made, to identify the obstacles that remain, and to bolster the mobilization of all around strategies that have been refined and strengthened in the light of lessons learned from a decade of experience on overcoming the HIV/AIDS epidemic.

I would first of all like to pay tribute to the President for the outstanding leadership and commitment that he has shown throughout the preparations for our meeting. I also commend all stakeholders in the global partnership, which has taken on form and substance in order to tackle a health challenge that the Security Council has rightly described as a threat to the security of us all. I would particularly like to express our appreciation to the Secretary-General of our Organization and to the Joint United Nations Programme on HIV/AIDS, who have submitted valuable, action-oriented recommendations for our consideration.

Since its appearance around 30 years ago, the HIV/AIDS epidemic, which has already caused more than 30 million deaths, has continued to expand. In 2009, 33 million people were HIV positive, a 27 per cent increase from 1999. Of that total, 66 per cent live in Africa, where HIV/AIDS, more than just a health scourge, is also in many cases a serious obstacle to socio-economic development because of the heavy toll it exacts on the continent's human capital and of the cost of programmes of prevention and care. In other words, the challenge of HIV/AIDS remains formidable, despite the progress that has been made in 10 years in terms of access to care.

Indeed, today 6 million patients have access to antiretrovirals in middle- and low-income countries, which is 37 per cent of the global average. For Africa in particular, that rate represents a notable increase, since in 2000 it was only 5 per cent. However, it is still broadly insufficient, since two thirds of the ill people are still without access to care. Caring for orphans — who now number around 16 million, the vast majority of whom are in Africa — and the rates of mother-to-child transmission of HIV/AIDS, which are high compared to those of other regions, also demonstrate the significant socio-economic burden the epidemic has inflicted.

While the resources allocated to the fight against HIV/AIDS, at both the national and international levels, have grown significantly over the last 10 years, their drop in 2009 and current trend towards stagnation are a source of concern. Mobilizing additional resources must be a key priority for the international community.

Effectively combating the spread of HIV/AIDS also requires that we contain and reverse the escalating cost of prevention and health care to ensure the broadest possible access to them. In this regard, the growing difficulties faced by countries that want the flexibility of access to essential medicines introduced by the Doha Declaration regarding Trade-Related Aspects of Intellectual Property Rights and public health are likely to weaken one of the pillars of the Declaration of Commitment. It is thus crucial that we remove the barriers that bilateral and regional trade agreements have erected against exports, imports and the production of generic medicines.

Cooperation and partnership with the pharmaceutical industry are also essential in order to speed up research into a vaccine and new, less toxic medicines that are longer lasting and easier to use. Upstream, too, much remains to be done to improve and simplify prevention and screening technologies. All this would facilitate greater community involvement in prevention and care activities and would promote earlier, and thus less expensive, treatment of patients.

The fight against the spread of HIV/AIDS, particularly in Africa, also requires strengthening health systems so that they may better meet the

demands stemming not only from HIV/AIDS but also from tuberculosis, malaria and the requirements of maternal and child health. Integrated treatment would create synergies that would have a positive impact on the effectiveness of the fight against HIV/AIDS.

All these areas have already been covered by the Abuja Declaration adopted at the Organization of African Unity summit on AIDS in April 2001, whose implementation has subsequently been regularly monitored by African Union entities.

To revitalize and reinforce the willingness of the international community to tackle this global plague in a spirit of solidarity and partnership, the key terms "zero infections", "zero discrimination" and "zero deaths" are undoubtedly the galvanizing themes that can guide national and international efforts to action that is most likely to bear results.

The objectives proposed by the Secretary-General deserve our commitment, because we believe they are achievable if the needs in terms of the appropriate capacities, resources and technologies are delivered through a strengthened international partnership. Moreover, at a time when efforts are turning towards making up for lost time in the implementation of the Millennium Development Goals, the imperatives surrounding the fight against poverty and renewal of the international partnership for development are most pertinent if we wish to curb the advance of illnesses, push back poverty and protect the health of women and children.

For its part, Algeria has sought since 1989 to implement a multidimensional and multisectoral approach by supplying the country with 61 anonymous screening centres, a national blood bank and eight treatment centres. This approach will enable us to contain the spread of HIV/AIDS, provide free access to medicines and antiretrovirals and significantly reduce the number of deaths caused by the virus and related infections. The very low rate of HIV/AIDS in Algeria is a testament to the appropriateness of this approach and encourages us to continue our efforts to make new progress in combating this illness.

The Acting President: The Assembly will now hear an address by His Excellency Mr. Ghulam Nabi Azad, Minister of Health and Family Welfare of India.

Mr. Azad (India): At the outset, I would like to compliment the President of the General Assembly on organizing this High-level Meeting on HIV/AIDS. The Secretary-General's report (A/65/797) has shown that the HIV/AIDS epidemic continues to outpace the response to contain and prevent its spread. That situation persists despite three decades of concerted effort to combat this epidemic.

Permit me with all humility to suggest that, along with declarations, we need an effective scaling up of our actions and resources if we wish to steal a march on this truly global epidemic. Our actions must match our words.

India has a strong prevention programme, which goes hand in hand with care, support and treatment. We have been able to contain the epidemic with a prevalence of just 0.31 per cent. We have also brought about a decline of 50 per cent in new infections annually. Over the last decade, we have seen evidence of the epidemic's stabilization, with definite success in reversal in some parts of the country. Our focus has been on high-risk groups, expanding services and improving access to antiretroviral therapy. The rollout of universal access to second-line antiretroviral therapy and early infant diagnosis is well advanced.

We are now at the threshold of commencing the next phase of the National AIDS Control Programme IV. Mother-to-child transmission of infection continues to be a great challenge. We aspire to achieve zero communication in newborns. Our strategy in India is to convert the 27 million annual pregnancies into institutional deliveries for efficacious preventive interventions through better detection of HIV positivity among pregnant women.

This year onwards, institutional deliveries at government health institutions are being made cashless. That means that diagnostic tests, drugs, diet and transport will be provided free of cost to all pregnant women and sick newborns. I am confident that this significant step will help in the elimination of HIV transmission from the mother to her newborn, in addition to further reducing the infant and maternal mortality rates and improving immunization levels.

We are also launching a new initiative to deliver male and female contraceptives at the household level.

We are conscious that persons infected with and affected by HIV still face stigma. That is not only a barrier to accessing services, but also a violation of

their rights. India is committed to fighting this stigma so that people living with HIV can live lives of dignity.

At today's critical juncture in our efforts to combat HIV/AIDS, it is imperative that the international community remain highly engaged. A foremost requirement is to bridge the resource gap. It is essential that the international community continue to commit funds commensurate with the requirement of containing HIV/AIDS.

In addition, the international community has to dismantle barriers that obstruct universal access to treatment. A key barrier is the high cost of antiretroviral medicines. Pharmaceutical companies in my country have been providing high-quality and affordable medicines, not only to India but also to approximately 200 countries. I would also like to take this opportunity to make it abundantly clear that those generic drugs are not cheap in terms of quality. It is important that considerations of commerce and profitability are not used to erect artificial barriers in matters of life and death.

I would also like to urge the international community to work together to remove barriers in the form of intellectual property rights and other barriers. We must ensure that all flexibilities in Trade-Related Aspects of Intellectual Property Rights must be used towards a better availability of affordable medicines. Therefore, we need proactive and collective action from the international community to dismantle these barriers and improve the availability of accessible, affordable and quality medicines for the needy and impoverished.

With these words, let me join others in reaffirming India's strong commitment and firm resolve to fight this epidemic in a concerted and more collaborative manner.

The Acting President: I now give the floor to His Excellency Mr. Abdulla Bin Khalid Al Qahtani, Minister of Health of Qatar.

Mr. Al Qahtani (Qatar) (*spoke in Arabic*): I am pleased at the outset to convey to the Assembly the warm regards of His Highness Sheikh Hamad bin Khalifa Al-Thani, Emir of the State of Qatar, and his wishes for the success of the work of this important high-level meeting. This meeting is aimed at strengthening cooperation in the area of promoting the response of the international community to the spread of HIV/AIDS, re-emphasizing the need for full and effective implementation of the Declaration of Commitment on HIV/AIDS (resolution S-26/2), adopted by the General Assembly in 2001, and the Political Declaration on AIDS (resolution 60/262), adopted by the General Assembly in 2006, reaffirming its support for the relevant resolutions.

I would like to take this opportunity to thank the United Nations Development Programme and other United Nations entities concerned with the reduction of the spread of AIDS for the pivotal role they play in strengthening the response of the international community to HIV/AIDS and to raising global awareness of the danger posed by this epidemic to public health and sustainable development in many countries of the world and its negative impact on economic growth in those countries.

Mrs. Waffa-Ogoo (Gambia), Vice-President, took the Chair.

I would also like to underline the commitment of the State of Qatar to support all efforts to reduce the spread of the epidemic and to promote measures that would reduce its negative impact on people living with the virus.

We have less than four years to achieve, by 2015, the goal of halting the spread of HIV and of beginning to reverse it. We must point out here that the international community must intensify its efforts; work on quickly implementing all the commitments it has made in past years to address the epidemic; take new and creative measures aimed at achieving that goal; undertake greater efforts in terms of prevention programmes, treatment, care and support for, and protection of the rights of, people living with the virus, and the elimination of all forms of discrimination against them; and ensure a reliable supply of antiretroviral medicines. This last goal is more attainable today than ever before, based on the effectiveness of these medicines in the most vulnerable societies.

No one can deny the positive impact of the international efforts aimed at raising awareness about reducing the spread of HIV. We in Qatar have been eager to be bound by previous relevant decisions, the most important of which is the provision of comprehensive care for people living with HIV/AIDS and the provision of support for them and for their families. We have worked to reduce the spread of the

disease through the programmes of the National Committee on HIV/AIDS, although the rate of infection remains low in our country. It is to be noted that we provide free treatment for those living with AIDS.

The Gulf Cooperation Council member States renewed their commitment to HIV-positive people at their meeting held in Saudi Arabia on 16 April 2011, at which we decided to combat AIDS in all fields and where a recommendation was made to provide comprehensive services including awareness-raising, prevention, diagnosis, treatment and integrated care.

The leaders of the Group of Eight (G-8) countries agreed in 2005 to provide additional aid in the amount of $50 billion aimed at combating the epidemic, of which $25 billion would go to Africa, by the year 2010. They identified new targets for universal access to antiretroviral treatment for HIV/AIDS, universal primary education and basic health care free of charge.

Again in 2007, the leaders of the G-8 reaffirmed their commitment to increasing development aid and announced an additional $60 billion to fight AIDS, malaria and tuberculosis. However, those commitments have in general not been respected. This will not help the international response to the pandemic, especially in developing countries, least developed countries and African and sub-Saharan countries.

Although the number of people living with HIV who receive antiretroviral medication exceeds 50 million, there are more than 10 million others who need immediate treatment. We therefore reiterate our call on the international community to intensify its efforts to help those countries to deal effectively with the epidemic.

However, this can be achieved as desired only if the major countries fulfil their financial pledges, since no matter what efforts are made by developing and least developed countries to fight HIV, they may not be effective in the absence of international support. In that regard, we should renew the commitments we made and accelerate their fulfilment by strengthening existing funding mechanisms and ensuring the continuation of the support needed by low- and middle-income countries in the areas of awareness, diagnosis and treatment.

The Acting President: I now give the floor to His Excellency Mr. Nuth Sokhom, Senior Minister and Chair of the National AIDS Authority of Cambodia.

Mr. Sokhom (Cambodia): First of all, on behalf of Samdech Akka Moha Sena Padei Techo Hun Sen, Prime Minister of the Kingdom of Cambodia, may I take this opportunity to express my sincere thanks to His Excellency Secretary-General Ban Ki-moon for honouring Cambodia by inviting us to this High-level Meeting on HIV and AIDS. May I also take this opportunity to express our appreciation for the convening of this important event and for this initiative to monitor progress and challenges and to find the way forward to solve the emerging issues related to HIV and AIDS.

On this auspicious occasion, on behalf of the Royal Government of Cambodia and the Cambodian people, may I extend my deep respect and gratitude to the Governments and peoples of friendly countries, our development partners, civil society organizations and the United Nations for their kind funding support, which has enabled us to achieve Goal 6 of the Millennium Development Goals. Because of that proud accomplishment, we received the United Nations Millennium Development Goals Award from the United Nations on 19 September 2010. Our success in Cambodia is a result of the combined collaborative efforts of legislative institutions, the Government, civil society organizations, the private sector, development partners, people living with HIV and AIDS and the networks of the most-at-risk populations.

Allow me to take this opportunity to pinpoint the following key achievements.

First, as a result of the great commitment and wisdom of our Prime Minister, in 1999 our National AIDS Authority was created as a leading mechanism of our comprehensive and multisectoral response to HIV and AIDS. It has now been extended at the regional level across the country. Since 1999, the 100 per cent condom use programme has been implemented all over the country. To ensure the effectiveness of our comprehensive response, the law on the prevention and control of HIV/AIDS was officially promulgated in 2002.

Secondly, with the deep and compassionate support of His Majesty the King and the active participation of our First Lady, Chair of the Cambodian Red Cross, there has been a remarkable reduction

across the country with regard to stigma and discrimination against people living with HIV and AIDS, including orphans and vulnerable children and their families.

Thirdly, Cambodia has clear policies and strategies to address the most-at-risk populations as a result of having created an enabling environment that in particular includes the active participation of communities and faith-based organizations.

Fourthly, through the initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Cambodia has been able to scale up the effectiveness of its prevention, care, treatment and support programmes to reach its targets on group, geographic and service coverage, nearly achieving our universal access target by 2010.

Cambodia has been successful in controlling the first wave of HIV and AIDS in the past decades. However, we are very concerned about the emerging situation and its underlying determinants. We are facing a second HIV and AIDS wave, in which the most-at-risk populations are being exposed to very fast-evolving conditions. Entertainment workers face special difficulties in implementing the 100 per cent condom use programme. There are increasing numbers of men who have sex with men and transgender people in cities and in provinces. Oral and injected drug use has significantly increased, especially among young people. Increased internal and cross-border mobility has increased the ranks of the vulnerable migrant and mobile population.

With the participation of all concerned stakeholders, especially development partners, we have developed our third national strategic plan for a comprehensive and multisectoral response to HIV/AIDS for the period 2011 to 2015, which includes seven strategic areas of focus. As part of that plan, seven national working groups have been assigned to take the lead in managing their respective priorities in each strategy area and to monitor their progress against targets. Along with that initiative, we are very mindful about capitalizing on deconcentration and decentralization efforts to promote a comprehensive and multisectoral response to HIV and AIDS that includes gender equity, so as to ensure the sustainability of our response by strengthening national and regional mechanisms.

At this historic meeting, I would like to take the opportunity to respectfully request bilateral and multilateral donors, and especially the Global Fund, to continue to help the Cambodian people in confronting the second wave of HIV and AIDS, as a contribution to the regional and global effort to pursue the implementation of the Paris Declaration on Aid Effectiveness.

Once again, on behalf of the Royal Government of Cambodia and the Cambodian people, I wish to extend my sincere gratitude and great appreciation for the efforts of Secretary-General Ban Ki-moon, along with the former Secretary-General, for their initiative in organizing the 2001 special session of the General Assembly and this High-level Meeting on HIV and AIDS, and especially for the creation of the Global Fund to assist poor countries, including Cambodia. I wish the Assembly success at this High-level Meeting.

The Acting President: I now give the floor to His Excellency Mr. José Ángel Córdova Villalobos, Minister for Health of Mexico.

Mr. Córdova (Mexico) (*spoke in Spanish*): We know that there are roughly 33.3 million people living with HIV in the world today and that new infections have declined by 20 per cent in the past decade. In what is perhaps one of the most visible advances towards universal access, we see that global coverage for antiretroviral treatment reached 36 per cent in 2009. Latin America is now the region with the highest coverage of antiretroviral treatment for those in need, some 51 per cent of whom receive it.

Countries must combine efforts and build regional and global alliances among nations and with other actors, including civil society organizations, people living with HIV, the academic and scientific communities, the United Nations and other cooperation authorities in order to respond effectively to the HIV/AIDS epidemic and meet the goals to which our countries committed in adopting the Declaration of Commitment on HIV/AIDS (resolution S-26/2) and the Political Declaration on HIV/AIDS (resolution 60/262), and thus also Millennium Development Goal 6.

The time has come to reaffirm our obligation to forge a vigorous, effective and sustainable multisectoral response for future decades. In order to improve that response to the epidemic and make more it effective, I would like to highlight the following

points. It is crucial that all countries set up sustainable mechanisms as soon as possible to provide antiretroviral treatment to all those in medical need, in a way that is timely, sustainable and permanently free of cost to the user. We must also work to reduce the costs and purchase price of antiretroviral treatment in low- and middle-income countries.

We also call for a redoubling of efforts to significantly step up prevention and health promotion strategies with a focus on those groups at greatest risk and most vulnerable to HIV, without neglecting other actions targeting the wider population.

As the Joint United Nations Programme on HIV/AIDS campaign states, "know your epidemic, know your response". For Mexico, it is crucial that, in the context of a comprehensive response to HIV/AIDS, we generate the best possible data so as to identify the groups affected by the HIV/AIDS epidemic and the social and personal health factors in play in that context.

The President returned to the Chair.

Along with all of the above, it is also extremely important to ensure greater visibility and attention to the needs of men who have sex with men, female and male sex workers, drug users, transsexuals and transgender persons, the youngest of whom are the most vulnerable of all. We must also keep in mind that adolescents and young people, migrant populations, vulnerable women and incarcerated persons are also in situations of heightened vulnerability to HIV infection.

Another priority for Mexico is the elimination of the vertical transmission of HIV and congenital syphilis. We are stepping up our efforts to implement immediate action. It is unacceptable that boys and girls continue to be born with HIV and/or syphilis. We will continue to strive to convince Governments of other countries of the importance of promoting user-friendly health services and comprehensive sex education as foundations for preventing new HIV infections in present and future generations.

To that end, we call on all countries represented here today to ensure that their actions are based on respect for human rights and to incorporate a focus on gender equality that allows for an effective response to HIV/AIDS that is free of stigma, discrimination, homophobia, transphobia and any type of violence. If we can forge a response to HIV/AIDS that encompasses all of these elements, we will have a robust and successful response to this epidemic.

This is not the time for complacency or censorship. Now is the time to tackle AIDS head on in our areas of expertise — Governments, the scientific community, civil society and the United Nations system. Let us move forward united.

The President (*spoke in French*): I now give the floor to Her Excellency Ms. Esther Murugi Mathenge, Minister of State for Special Programmes of Kenya.

Ms. Mathenge (Kenya): I bring the Assembly greetings from my President, His Excellency Mr. Mwai Kibaki, and the people of Kenya.

I take this opportunity to commend you, Mr. President, and the Chairpersons of the sessions during this High-level Meeting on HIV/AIDS for your dedication in facilitating our deliberations. Likewise, I express our appreciation to the Secretary-General for his detailed and focused reports on issues pertinent to the HIV/AIDS epidemic. My delegation joins the international community in paying tribute to the souls lost to the scourge of HIV/AIDS and to those infected and affected by it.

Kenya is one of the 189 countries that adopted the Declaration of Commitment on HIV and AIDS (resolution S-26/2) at the special session on AIDS in 2001. It is now 10 years since the Declaration was adopted, and Kenya has taken stock of progress made so far in our national response to HIV and AIDS.

Kenya has been implementing a multisectoral response to the HIV and AIDS epidemic since 1999 and has currently rolled out its evidence-informed third Kenya National AIDS Strategic Plan 2009-2013, based on the premise of "know your epidemic, know your response". The Kenyan HIV epidemic has the characteristics of both a generalized epidemic among the mainstream population and a concentrated epidemic among certain key affected populations. These are men who have sex with men, the prison population, sex workers and their clients, and people who inject or use drugs.

A number of milestones have been achieved to date. The number of individuals aged 15 years and above who have received testing and counselling has steadily increased from 860,000 in 2008 to 5,738,282 in 2010. However, we would like to scale this up to at least 80 per cent of all eligible people by 2015. The

national target for coverage for the prevention of mother-to-child transmission was 80 per cent, but we had surpassed this, reaching 82 per cent, by December 2010. We want to scale this up to 100 per cent by 2013.

Knowledge on prevention has increased. Condom demand has risen from 8 million per month in 2005 to 20 million per month in 2011. Voluntary male medical circumcision rates have risen. Over 200,000 adult men from non-circumcising communities within the Republic have been circumcised under this programme since its inception in 2009.

Treatment, care and nutrition have improved. Currently 432,000 out of 650,000 people requiring antiretroviral therapy are receiving it. This is based on World Health Organization guidelines. The number of people on antiretroviral therapy should be scaled up to 80 per cent by 2015. Retention of treatment, after 12, 24 and 60 months, stood at 80, 72 and 71 per cent, respectively. We want to increase these numbers to 85 per cent across the board.

On the issue of orphans and vulnerable children, by 2009 we had close to 1.2 million children who had lost either one or both parents to HIV and AIDS. We have a cash transfer programme that now reaches 300,000 girls and boys.

We have encountered a number of challenges. First is the feminization of the HIV and AIDS epidemic, which is driven largely by biological factors, inadequate economic empowerment and access to sexual and reproductive health services, and gender-based violence.

Stigma, discrimination and widespread homophobia occur among the key affected populations. HIV prevalence has stabilized in Kenya at between 6 and 7 per cent over the past 5 years. However, the number of annual new infections is still very high, at 122,000 — 100,000 adults and 22,000 children. We hope to reduce that number by 50 per cent by 2013 and to achieve zero new infections in children by 2015. There are still more than 300,000 people in Kenya who are eligible for antiretroviral treatment but are not receiving it.

We call for global solidarity in combating stigma, discrimination and the exclusion of key affected populations through the re-examining of punitive laws in the context of the human rights of all people and protecting the sexual and reproductive health of women and girls.

We also call for strong, inspiring, visionary and informed leadership, which is required not only from the Government but from all players. A balance also needs to be struck between prevention, treatment, care and support by ensuring national ownership and the appropriate resourcing of HIV responses, the provision of high-quality sexuality education and reproductive health services, and harm reduction while endeavouring to improve access to HIV commodities and affordable antiretroviral therapy. We should also embrace new scientific evidence in prevention.

We call upon the international community to invest in the development of new HIV and tuberculosis prevention and treatment technologies suitable to the regions most affected. That is important because, as a country, we have adopted the Joint United Nations Programme on HIV/AIDS vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

The President (*spoke in French*): I now give the floor to His Excellency Mr. Naman Keïta, Minister of Health of Guinea.

Mr. Keïta (Guinea) (*spoke in French*): I should like at the outset to convey to all present, on behalf of the President of my country, Mr. Alpha Condé, and the Government of Guinea, our sincere greetings and to express my satisfaction at being able to participate in this High-level Meeting.

Guinea is a country where national HIV prevalence is relatively low, at 1.5 per cent; however, the epidemic is affecting sectors that are key to socio-economic development in my country. The groups most affected are men in the uniformed services, fishermen, truckers and miners; prevalence in those groups ranges from 5 to 6 per cent.

Since the outbreak of the epidemic, Guinea has affirmed its commitment to eradicate HIV. Concrete results have been achieved, in particular with the support of technical and financial partners, to which we would like to express our sincere gratitude. However, those achievements have not been sufficient, and major challenges include the insufficient national leadership and a dearth of local financing.

Given countries' dependence on external financing, the global economic crisis that is affecting

donors and the increasing poverty in African countries, the achievements that have been made in addressing the issue of AIDS are now at risk. That is why combating HIV/AIDS is one of the priorities of the new Government of Guinea. Concrete measures have been taken include greater involvement by the Prime Minister, the setting up of a line of credit in the national budget, and the establishment of a mechanism for the local mobilization of resources.

As we call once again for technical and financial partners to support Guinea in particular and African countries in general, my President is also launching an appeal to his peers with a view to devising innovative solutions in connection with the local financing of the response at the national and continental levels, including with respect to the production of medication.

Long live African solidarity, and long live international cooperation. Together we will defeat AIDS.

The President (*spoke in French*): I now give the floor to Her Excellency Vabah Gayflor, Minister of Gender and Development of Liberia.

Ms. Gayflor (Liberia): I bring warm greetings from Her Excellency Mrs. Ellen Johnson Sirleaf, President of the Republic of Liberia, and the people of Liberia. I should like also to thank the organizers of this important High-level Meeting devoted to a comprehensive review of the progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS (resolution S-26/2) and the 2006 Political Declaration on HIV/AIDS (resolution 60/262).

This meeting is taking place at a crucial time. In just under four years, by 2015, the world community will be taking stock of our individual and collective efforts to attain the Millennium Development Goals (MDGs). Of particular relevance to today's gathering is MDG Goal 6, which reflects our collective ambition to halt and begin to reverse the spread of HIV and AIDS by 2015.

Our aspiration in Liberia, in responding to the HIV/AIDS epidemic, is to create an HIV/AIDS-free society, and thereby contribute to the creation of a global community of societies free of HIV/AIDS. Our collective vision of a world free from the scourge of HIV and AIDS brings us all together to provide the leadership needed to defeat this global pandemic.

The global battle against HIV and AIDS is a major challenge for us all. Recognizing the magnitude of this battle, Liberia has launched a new phase of our HIV prevention programme which targets young people aged 15 to 25 years. At the same time, we will keep in sharp focus the needs of women, who continue to bear a disproportionate burden of the disease in Liberia and globally.

At the end of 2011, Liberia will complete the implementation of its first post-war development agenda, the poverty reduction strategy. Through the strategy, Liberia is accelerating the process of recovery and development after more than 14 years of civil conflict. The issue of HIV/AIDS has been mainstreamed into each of the four pillars of the strategy and therefore reflects the shared responsibilities of all ministries and agencies.

From an historical perspective, the first case of AIDS was diagnosed in Liberia in 1986. In response, the Government of Liberia created a national AIDS control programme. In 1987, a national AIDS commission was also established. However, due to the civil crisis, those programmes fell apart in 1990. Today, we are pleased to report that since 2007 the National AIDS Control Program has been expanded and restructured. In 2007 the National AIDS Commission was similarly reconstituted under the leadership of the President, who chairs it personally. Progressive measures such as these have enabled the Government to expand treatment to all of Liberia's 15 counties.

Additionally, our reconstituted AIDS Authority has developed a new national strategy, guided by the "Three Ones" principles of the Joint United Nations Programme on HIV/AIDS: one national AIDS authority, one national strategic framework and one national monitoring and evaluation system.

Liberia has also stepped up data collection to determine the prevalence of HIV and AIDS in the country. Information is now available on HIV prevalence from a 2007 demographic and health survey and three prenatal sentinel surveillance surveys carried out between 2006 and 2008. In 2007, surveys showed a national HIV prevalence of 1.5 per cent among the general population, with rates for women at 1.8 per cent and for men at 1.2 per cent, of a total population of 3.5 million. In 2008, the prenatal surveillance data

also showed that more women were infected, with a prevalence of 4 per cent.

Women and girls constitute 58 per cent of the 36,000 people living with HIV in Liberia. The differences in HIV prevalence between women and men are particularly striking in the younger age groups, with three times more women than men in the 15-to-24-year-old age group.

Given its small size and population, Liberia cannot ignore the impact this pandemic has had on national efforts to achieve social and economic recovery and development. We also believe that this disease presents a very serious challenge to our human development goals, and we therefore support the Secretary-General's report (A/65/797), which urges zero new infections, zero discrimination and zero AIDS-related deaths.

With regard to its achievements to date, the Government of Liberia is proud of the modest gains in its AIDS response in recent years, made possible through strong partnerships with multilateral and bilateral donors. Here I would like to make special mention of the unwavering support provided by the Global Fund to Fight AIDS, Malaria and Tuberculosis, which was simply indispensable. My Government therefore joins others in appealing to donors to replenish the Global Fund in order to advance work towards achieving the three zeros.

I would like to share a few of the gains made in our AIDS response. We have developed a monitoring and evaluation plan with specific gender indicators. Of the 10,028 persons needing treatment, 42 per cent have been placed on antiretroviral therapy. Testing and counselling services for expectant mothers have been expanded by increasing the number of services for preventing mother-to-child transmission from 29 to 162. We have also strengthened the national network of persons living with HIV and AIDS so as to support prevention and treatment efforts.

Today Liberia is resolved to fight HIV and AIDS. To succeed, we must maintain an environment of peace and stability. We must also address poverty and illiteracy, consistently promote the rights of women and girls, improve our health care system and respond to the other important targets expressed in the Millennium Development Goals.

We wish to offer our appreciation to the Member States of the United Nations for the investments made in Liberia through the United Nations Mission in Liberia and other United Nations agencies. We will continue to count on the leadership of every Member State to help us sustain the gains Liberia has made and to confront and overcome the threat that HIV and AIDS pose to our aspirations for national development.

Clearly, we face a daunting challenge, and we all remain responsible partners in the global fight against the disease. It takes commitment, the right strategy and the collective efforts of all of us to achieve this goal. There is no better time than now, when our collective efforts are most needed in the global battle against HIV and AIDS.

We would once again like to express our appreciation and to thank and congratulate you, Mr. President, and the world body that continues to stand with every one of us as we fight this battle with AIDS.

The President (*spoke in French*): I now give the floor to His Excellency Mr. Ruhal Haque, Minister of Health and Family Welfare of Bangladesh.

Mr. Haque (Bangladesh): Mr. President, I thank you for presiding over this High-level Meeting on HIV/AIDS. I would like to convey our appreciation to the Secretary-General, Mr. Ban Ki-moon, and to the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Mr. Michel Sidibé, for their comprehensive briefings this morning. Our thanks also go to Ms. Tetyana Afanasiadi of the Global Network of People living with HIV/AIDS and Ms. Mathilde Krim of the Foundation for AIDS Research for their speeches.

At the outset, I would like to recall the meeting our Prime Minister, Sheikh Hasina, had with the Executive Director of UNAIDS in Geneva. Our honourable Prime Minister committed to supporting an enhanced national response to HIV/AIDS. She could not be here, due to other duties, and asked me to represent her.

This High-level Meeting demonstrates the willingness and commitment of Member States to banish the scourge of HIV and AIDS from our planet. I believe it will provide a real opportunity for countries to commit to finding new ways forward in tackling AIDS and to produce a strong declaration to guide

global efforts to reach universal access to HIV prevention, treatment, care and support by 2015. The attendance of a good number of civil society representatives and other actors in the AIDS movement has also added value to our collective response to curbing the menace.

We have had success in fighting HIV/AIDS in the past as a result of global initiatives. However, it is a matter of great concern that despite substantial progress over the three decades since AIDS was first reported, more than 7,000 new cases of HIV infection occur every day, with women and adolescent girls facing a disproportionately higher risk.

It is disheartening to note that people between the ages of 15 and 24 accounted for 41 per cent of new infections among adults in 2009. Worldwide, an estimated 5 million young people in that age group were living with HIV. For most of them, HIV infection is the result of biological vulnerability, social inequality, neglect, exclusion and violations that occur with the knowledge of families, communities and social and political leaders.

It is therefore high time to build a chain of prevention to keep adolescents and young people informed, protected and healthy. We have included HIV/AIDS education in our national curriculum for grades 6 to 12. We must protect adolescent girls and young women so that the journey from childhood to adulthood is not thwarted by HIV. I urge family members, teachers and community leaders to play a constructive role in setting strong standards for responsible behaviour and advocating for the full range of services needed for young people to stay healthy.

The HIV and AIDS epidemic inflicts a disproportionate burden on women and girls and is a major hindrance to the empowerment of women and to gender equality. I urge Member States, relevant United Nations entities and other pertinent stakeholders to support the development and strengthening of the capacities of national health systems so that women living with HIV are provided with sufficient assistance.

Bangladesh is still considered a country with low HIV/AIDS prevalence. However, it is highly vulnerable to it. There are 2,088 HIV-positive and 850 full-blown AIDS-infected patients in the country, and the HIV prevalence in the adult population is less than 0.01 per cent. Sometimes, HIV infection is unreported because there is also a social stigma attached to it.

The underlying causes of the epidemic include poverty, gender inequality and the high mobility of the population, all of which are present in Bangladesh, a densely populated country with about 150 million inhabitants. Emigration to other countries for employment is very common, particularly among younger people. There is a considerable risk to that group, and we support international initiatives on HIV/AIDS services for migrant populations. Through girls' education and gender-based development movements, Bangladesh has made progress in promoting gender equality in the past two decades.

However, the low level of knowledge, low condom use, unsafe professional blood donations, the lack of an appropriate environment, men having sex with men and the spread of disease in neighbouring countries could all contribute to the spread of HIV in Bangladesh. The level of infection among injecting drug users also poses a risk. We must continue to provide support to the population most at risk. My delegation believes that there is a significant risk of HIV in Bangladesh. Global and regional efforts, together with national efforts, must be continued to prevent it. I draw the attention of relevant stakeholders to that factor.

Before concluding, my delegation calls upon developed countries to enhance financial support to developing countries, including through capacity building and the elimination of barriers, such as intellectual property rights, to lower the cost of medicines or make them affordable, so as to enhance their preventive capacity to fight the threat of HIV/AIDS. We also call for a global initiative for access to generic antiretroviral treatment.

Finally, we emphasize that, considering the threat, there is no scope for complacency. We should aim for zero infections, zero discrimination and zero AIDS-related deaths through concerted efforts and strategies, which are the shared responsibility of all of us on this planet.

The President (*spoke in French*): I now give the floor to His Excellency Mr. John Seakgosing, Minister for Public Health of the Republic of Botswana.

Mr. Seakgosing (Botswana): Botswana is indeed privileged to be here on this occasion to join other nations and delegations at this important High-level Meeting, which provides us all with an opportunity to collectively reaffirm our commitment and resolve to

realize the results of the declarations that we have made to respond to this singular epidemic, which remains a global crisis.

While, over the past decade, our country has embarked on a number of intensive interventions to address the epidemic, our people continue to be infected. The sobering reality is that the estimated HIV prevalence among the general population in Botswana remains significantly high at 17.6 per cent, which translates into about 350,000 people living with the HIV infection. The HIV prevalence among Botswana women is about 20.4 per cent, compared to 14.2 per cent prevalence among men. That reflects the growing feminization of the epidemic at home, as well as in the rest of the world.

However, we have made some positive achievements towards universal access. The percentage of HIV-positive pregnant women receiving the complete course of antiretroviral treatment to reduce the risk of mother-to-child transmission stands at 94 per cent — 3 percentage points short of our universal access target of 97 per cent. Also, we have been able to surpass the global elimination target of less than 5 per cent mother-to-child transmission. Now, our new target is a further 1 per cent reduction.

In Botswana, more than 93 per cent of adults and children starting antiretroviral therapy survive beyond the first 12 months, as compared to our target of 97 per cent. We have also achieved 100 per cent coverage for orphans and vulnerable children in need of social and material support.

Such successes have been realized through strong leadership at the political and national levels. Significant domestic resources have and continue to be channelled into the national response. Sacrifices have been made in development objectives so as to ensure access to quality HIV and AIDS services for all who need them, especially medication. That reflects Botswana's commitment to the full realization of the right of all to the enjoyment of the highest attainable standards of physical and mental health.

The Government of Botswana continues to seek new and innovative ways to meet the challenges of universal access within the context of a dynamic and rapidly changing epidemic. We recently launched our second national strategic framework for HIV and AIDS, for the period 2010 2016. It outlines the country's prioritized intervention, namely, in the areas of prevention, systems strengthening, strategic information management and the scaling up of treatment, care and support. Such strategic priorities are being given significant thrust through the development of a cost-stagnation operational plan.

It makes us very proud that Botswana's national goal of zero new infections, as enshrined in our developmental Vision 2016, has been adopted as the new global goal. In order to achieve such a goal, our efforts will focus on a sound balance between behavioural and biomedical prevention interventions, within our specific social, cultural, economic and structural determinants of risk and vulnerability.

Central to all those efforts is respect for human rights and the expansion of service delivery to reach key affected populations, including those most at risk. The Government of Botswana continues to work to ensure that HIV investments reflect the imperative of women's empowerment and gender equality. We are adopting the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV of the Joint United Nations Programme on HIV/AIDS to ensure that our national response is adequately and comprehensively sensitive to their needs.

To that end, we welcome the establishment of UN-Women and look forward to working with it at the country level to strengthen our efforts to address gender inequalities and gender-based abuse and violence and to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection.

We shall continue to explore all possible means to forge ahead to meet new and ambitious targets while sustaining the level of coverage and service quality we have already attained. We are dedicated to making gains in efficiency and cost-effectiveness while examining alternative and innovative mechanisms for increasing domestic resources available for the response.

We are also committed to achieving catalytic synergies between the response to HIV/AIDS and other important development objectives. But the reality is that in order to accelerate progress towards a future of zero new HIV infections, zero discrimination and zero AIDS-related deaths, without eroding the gains of the past decade, Botswana will require sustained financial commitments from the United Nations family, donor Governments and the Global Fund.

We have come so far, but there is a long road ahead. Botswana joins its fellow Member States here assembled in reaffirming its commitment to implementing the declarations we have made and urges the international community not to become complacent in the face of long-term demands and responsibilities. We stand at the brink of global change and we must show solidarity, leadership and courage if we are to achieve our goals and create a world without HIV and AIDS.

The President (*spoke in French*): I now give the floor to His Excellency Mr. Keith Mondesir, Minister of Health, Wellness, Family Affairs, National Mobilisation and Gender Relations of Saint Lucia.

Mr. Mondesir (Saint Lucia): Saint Lucia aligns itself with the statement made by the Prime Minister of Saint Kitts and Nevis, who spoke on behalf of the Caribbean Community.

The Caribbean has been identified as the region with the second highest prevalence of HIV infection among adult men. In Saint Lucia, the prevalence is estimated to be less than 1 per cent in the general population, with the number of new infections appearing to be stable over the past five years.

Saint Lucia welcomes this High-level Meeting as an opportunity to discuss the best practices and efforts among Member States and to undertake a comprehensive review of the progress we have achieved so far. Our national response has recorded many gains in the past 10 years, including free voluntary counselling and testing, a reduction in the number of AIDS-related deaths as a result of Government-provided antiretroviral treatment, a reduction in mother-to-child transmission, with zero new cases reported since 2006, and a decline in the number of new reported cases of HIV/AIDS over the past five years.

While that progress is encouraging, Saint Lucia continues to face many challenges in providing a comprehensive response to the epidemic. We are grateful for technical support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), which have helped us to identify the need for a two-phase approach in the future. Phase one is the commitment to address the disease through science- and evidence-based approaches, enabling us to better identify the national and regional character of the transmission of HIV/AIDS in our region in order to develop a targeted response. Phase two will entail an increase in testing, treatment and prevention, recognizing that these three components are all aspects of treatment and prevention and are most effective when provided together.

Saint Lucia, in consultation with UNAIDS, recognizes the need to develop an evidence-based response to the disease that addresses the situation that we are facing currently. An evidenced-based prevention and treatment programme enables a coordinated effort throughout the country in prioritizing resources and actions to groups that are most at risk and most vulnerable. We are committed to working with partners and experts to improve our understanding of the particular nature of the disease in Saint Lucia and to develop a response tied to our local experience and situation.

This shift from a generalized approach to a concentrated one, which prioritizes and addresses those most at risk, will enable us to provide a more sustainable response that can be implemented at the country level. Such a response is critical, as Saint Lucia is currently facing a transition in which a number of significant external grants and partnerships are coming to an end. Consequently, it is imperative that our resources and efforts be deployed in the most effective manner possible to reach those who are most at risk.

Based on the evidence we have about the spread of the disease, our national strategic plan, which was drafted with the technical support of UNAIDS and the WHO, has identified major sectors of the population that are most at risk, namely, in order of priority, men who have sex with men and sex workers. Another priority will be to ensure that we eliminate mother-to-child transmission.

In addition, we have identified young people, and girls in particular, as a group that is vulnerable given current behaviours and knowledge about the spread of HIV. Education for young people will include an emphasis on the risks associated with early sexual debut and encouraging the postponement of sexual debut for both boys and girls. However, the biological vulnerability of girls will be emphasized, as the fact that girls are 50 per cent more vulnerable to sexually transmitted infections and HIV must be made clear to all.

Given the nature of the disease in Saint Lucia and following our experiences over the past many years of intervention, we are committed to addressing diseases in the following way.

In order to steward scarce resources and enable the best care and treatment to be provided to those who are most at risk, we will focus efforts on treating the epidemic in a concentrated fashion, which will focus on linking testing to care. Voluntary confidential testing is a critical factor in reducing the transmission of disease and identifying those who require care and support. Testing and care must be linked in order to ensure that the social and human support required by those who have tested positive for HIV and AIDS is provided. Integrated care has been identified as one of the priorities in securing better treatment going forward.

Good care is part of prevention. Humane programmes that are person-centred and provide social support and additional care for those who are marginalized and vulnerable are essential to treating the whole person. In addition to care and treatment programmes, prevention programmes that address high risk groups as well as the generalized population, and which provide strong messages regarding the dangers of concurrency, will be developed. In this context, the promotion and support of healthy sexual behaviour is essential. An emphasis on programmes to achieve this objective will be continued, building upon existing health and family life education programmes in schools towards the development of greater community and civic involvement, in support of young people in particular, in the adoption of healthy behaviours.

Saint Lucia reaffirms its commitment to combating this disease by ensuring that the resources we have are used most effectively. We continue to prioritize addressing high-risk communities and providing them with the support and resources they require, while also emphasizing healthy sexual behaviours and ensuring that an emphasis on prevention is clearly provided to young people who comprise the high-risk groups, as well as all individuals, groups and communities in Saint Lucia at large.

The President (*spoke in French*): I now give the floor to His Excellency Mr. Rudyart Spencer, Minister of Health of Jamaica.

Mr. Spencer (Jamaica): My delegation joins others in congratulating you, Mr. President, on presiding over this important High-level Meeting. I also commend Secretary-General Ban Ki-moon for his initiative in convening this Meeting to review global progress achieved on our earlier commitments with regard to HIV and AIDS.

At the outset, my delegation aligns itself with the statement made by The Honourable Denzil Douglas, Prime Minister of Saint Kitts and Nevis, who spoke on behalf of the Caribbean Community. Allow me, however, to make a few remarks in my national capacity.

Jamaica acknowledges the considerable investment that the international community, led by the United Nations, has made in the fight against HIV and AIDS for many decades. Indeed, it is that global support that has allowed countries such as Jamaica to make a difference in the lives of many persons who are infected and affected by HIV/AIDS. The progress that has been made in Jamaica is noteworthy.

In 2009, there was an 18 per cent decline over 2006 in the number of persons reported with advanced cases of HIV/AIDS. AIDS deaths have also declined significantly, from 665 in 2004 to 378 in 2009. Paediatric AIDS deaths also declined by 19 per cent, from 32 cases in 2008 to 26 cases in 2009. The expansion of HIV testing in the public sector has resulted in treatment coverage for about 84 per cent of pregnant women and 98 per cent of babies delivered in the public sector. Early testing has resulted in the timely provision of antiretroviral treatment, leading to reduced mother-to-child transmission, which now stands at less than 5 per cent. Despite those advances, Jamaica faces challenges relating to inadequate human resources in order to effectively scale up testing, treatment and support services.

Tight fiscal constraints, which are not unique to Jamaica, undermine the Government's commitment to advance effective HIV and AIDS strategies in any significant way. The country will need the continued consistent support of the donor community, not just to maintain the gains that we have made but to make great leaps forward in the achievement of various international targets relating to HIV/AIDS, in particular for persons living with the disease — especially those who are marginalized, including our

most at risk populations, such as men who have sex with men, sex workers and crack cocaine users.

Jamaica looks forward to the outcomes of these deliberations and joins the rest of the world in commending the stewardship and leadership of the General Assembly.

The President (*spoke in French*): I now give the floor to His Excellency Mr. Henry Madzorera, Minister for Health and Child Welfare of Zimbabwe.

Mr. Madzorera (Zimbabwe): Zimbabwe is pleased to participate in this High-level Meeting that seeks, among other things, to craft a way forward in the global response to the HIV and AIDS epidemic. To that end, I thank the Secretariat for its reports that provide the basis for our deliberations.

Allow me to align myself with the statement made by The Honourable Richard Kamwi, Minister of Health and Social Services of Namibia, on behalf of the Southern African Development Community.

Pursuant to our universal access commitments, over the years Zimbabwe has scaled up its national response to HIV and AIDS while being guided by specific targets and indicators of the declaration on universal access, namely, the Political Declaration on HIV/AIDS (resolution 60/262).

In that regard, Zimbabwe's HIV prevalence has continued to decline, from a high of over 29 per cent in 1999 to the current 13.7 per cent. That decline has also been consistent with the decline in the incidence of HIV. The declines in both areas have been underpinned, among other things, by expanded access to HIV prevention services, including on the prevention of mother-to-child transmission, as well as the provision of male and female condoms, HIV testing and counselling and awareness-raising campaigns. We recently added male circumcision to our HIV prevention programmes, following compelling evidence that if it is offered to many men and taken up appropriately, the practice offers potential benefits in HIV prevention.

Following the adoption of the universal access Declaration, in 2006 Zimbabwe was perhaps among the first in the world to develop and implement an evidence-based behaviour-change strategy whose primary outcome has been the reduction of new HIV cases. Evidence has already been noted that the behaviour-change strategy has contributed to an increased demand for, and uptake of, HIV prevention services.

To enhance the utilization of testing and counselling services as a gateway to treatment and care, Zimbabwe introduced provider-initiated testing and counselling services in all health institutions. This proactive service has made our testing and counselling services user-friendly and robust by enhancing services already provided under voluntary testing and counselling services.

Despite the funding challenges, Zimbabwe has also recorded significant progress in the provision of treatment and care services. By the end of 2010, Zimbabwe had achieved 77 per cent coverage towards our universal access target, wherein 350,000 of an estimated 593,000 individuals who required antiretroviral therapy were accessing antiretrovirals.

Although the achievement of universal access in treatment and care was well within reach in 2010, Zimbabwe took a deliberate step to ensure that people needing treatment could access drugs when they still looked and felt healthy and were likely able to respond well to treatment. In that regard Zimbabwe adopted the World Health Organization's newly revised treatment guidelines, raising the threshold for the initiation of treatment to a CD4 cell count of 350, up from 200. Based on that adjustment, the demand for treatment services immediately rose, with 593,000 clients now needing treatment.

In pursuit of universal access targets, Zimbabwe has expanded and decentralized treatment services to all districts as well as various rural health centres, opening new antiretroviral therapy sites at all levels. Regular outreach campaigns penetrating into villages and farming and mining communities have resulted in an increased uptake of treatment services, as well as the reduction of stigma and discrimination.

Against the backdrop of increased external support in this area, Zimbabwe has also recorded a significant increase in the number of children accessing antiretroviral drugs. The number of children on treatment, which is 10 per cent of the total population, has doubled in the past two years. Efforts are in place to ensure that this service is expanded so that many more children can access treatment. Part of the effort includes the creation of an enabling environment wherein the bottlenecks that result in access challenges are eliminated. The increase in the number of children

accessing treatment and care services has benefited from a deliberate effort by Zimbabwe to expand the coverage of services for the prevention of mother-to-child transmission, the introduction of early infant diagnosis and the mobilization of communities to participate in prevention services.

In pursuit of universal access, Zimbabwe has also strengthened collaborative tuberculosis/HIV interventions, whose impact has already been immense in the scaling up of treatment and care services. As part of our commitment to, and pursuit of, universal access, Zimbabwe has now switched to the use of more efficacious regimens and is slowly phasing out certain old triple-dose regimens whose efficacy was comparatively lower.

I would like to salute our partners for the assistance they have rendered Zimbabwe in the area of treatment and care. To mention but a few, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the HIV/AIDS Expanded Support Programme, the United States President's Emergency Plan for AIDS Relief, the Children's Investment Fund Foundation, the Clinton Health Action Initiative and the Bill and Melinda Gates Foundation have played central roles in enabling Zimbabwe to expand access to treatment and care services.

Zimbabwe recognizes that the achievement of universal access targets requires an adequately enabling environment. As such, we have created structures for proper coordination and implementation in a multisectoral approach. Under that approach, our Government enacted relevant legislation for the creation of the National AIDS Council and the National AIDS Trust Fund. These institutional arrangements are supported by various sectoral policies that seek to promote the achievement of universal access targets. Indeed, the effectiveness of these institutional arrangements has been recognized both regionally and internationally and has been subject to study and analysis as a best practice by many.

Spurred by improvements in the performance of the economy since the adoption of a multi-currency regime, our home-grown AIDS levy has already started to claim its place in our financing strategy and is already playing a significant role. Our pursuit of universal access is set to tremendously benefit from Zimbabwe's recently developed results-based HIV and AIDS strategic plan.

Let me conclude by saying that there have been many challenges in pursuing the universal access targets. Despite those challenges, we are hopeful that Zimbabwe will scale up interventions and eventually achieve universal access to HIV prevention, treatment and care in the shortest possible time.

The President (*spoke in French*): I now give the floor to His Excellency Mr. Georges Moyen, Minister for Health and Population of the Republic of the Congo.

Mr. Moyen (Republic of the Congo) (*spoke in French*): In taking the floor here today during this High-level Meeting on HIV/AIDS, I would like first of all to convey to the General Assembly the warm greetings of the President of the Republic of the Congo, His Excellency Mr. Denis Sassou Nguesso. He has authorized me to express the firm commitment of the Congolese Government to support in every possible way the actions set out in the 2001 Declaration of Commitment on HIV/AIDS (resolution S-26/2) and the 2006 Political Declaration on HIV/AIDS (resolution 60/262). I would therefore like first to speak about the progress that the Congo has made in combating AIDS. Thereafter, I shall share with the Assembly the concerns and challenges that have emerged in the response. I shall conclude by referring to the prospects for new impetus in our work.

In an effort to take concrete steps to fulfil the commitments undertaken by the Congo, in July 2003 our President took the initiative to establish an institutional framework to serve as a guide for advocacy and coordination. Two subsequent strategic frameworks were also created, enabling us to structure our national response and to take into consideration national and international concerns. Accordingly, we have taken the following steps to achieve universal access to prevention, treatment, care and support for those living with HIV, as well as to achieve the Millennium Development Goals. We provide free HIV screening, lab tests and antiretroviral drugs. We have also adopted a judicial framework and increased budget allocations to finance efforts to combat AIDS.

All these steps have been implemented on the ground through preventive actions and by addressing HIV and sexually transmitted diseases and HIV. The prevalence of HIV declined from 4.1 per cent in 2003 to 3.2 per cent in 2009. The number of patients receiving antiretroviral therapy increased fourfold in

five years — from 4,000 in 2006 to 16,000 today, including 1,000 children.

While we welcome the results so far, there are still other challenges to overcome. We need a sustainable ongoing partnership to fund prevention programmes and global treatment programmes. I must express here our appreciation for all the international initiatives that have been adopted, for Africa in general as well as for the Congo in particular, to finance the fight against HIV/AIDS and other infectious diseases. I should also express our gratitude to the networks of people living with HIV and other civil society organizations, whose commitment to supporting State institutions deserves every possible encouragement.

The Congo is nonetheless still concerned by the feminization of the epidemic, by the particular vulnerability of indigenous peoples to HIV and by the issue of TB/HIV co-infection. For those reasons, the measures we take as a country will focus especially on eliminating mother-to-child transmission, improving treatment for TB/HIV co-infection, increasing access to services for indigenous people and affirming female leadership — all in the service of universal access.

The President (*spoke in French*): I now give the floor to Mr. Paijit Warachit, Permanent Secretary for Public Health of Thailand.

Mr. Warachit (Thailand): It is time yet again for us, the nations of the world, to unite for universal access. For Thailand, this goal and principle are the foundations of our national HIV/AIDS response. We have struggled hard to reach this goal. Now we are committed to moving beyond it to zero new HIV infections, zero discrimination and zero AIDS-related deaths.

Since the High-level Meeting on HIV/AIDS in 2006 (A/60/PV.86), Thailand has made substantial progress in the prevention of HIV infection among the general population and of mother-to-child transmission. Current coverage includes nearly 97 per cent of women in need. Access to HIV treatment, care and support is now a reality for nearly 80 per cent of all in need. In addition, some services have been expanded to non-nationals and people in remote areas, which include migrant workers and ethnic minorities. Government and civil society enjoy a close and effective partnership on both prevention and care, while the private sector continues to play an active part. Meanwhile, we are striving in a comprehensive manner to eliminate stigma and discrimination.

In Thailand, we project that, over the next five years, certain key affected populations will account for more than 90 per cent of new infections. These include men having sex with men, sex workers, injecting drug users and partners in a relationship in which one of them is unknowingly or knowingly HIV positive. On our course to the three zeroes, we are working not only to optimize and consolidate what Thailand has done well; we must also emphasize innovation and change in focusing on prevention. We must also address the legal, social and environmental factors that hinder access to prevention and care services, as well as the factors that fuel stigma and discrimination.

In order to achieve zero new infections, we will focus on areas where most infections occur in terms of specific groups and geographic areas. For Thailand, a rights-based and gender-sensitive approach is integral to providing high quality prevention services to all key populations.

In order to rapidly scale up our prevention response, we have decided to pilot innovative financing models, including a country prevention fund. We also aim to strengthen local ownership, leadership and capacity to manage HIV/AIDS response. This, we hope, will be key to our success in getting to zero.

Thailand recognizes that HIV is more than a health challenge. That is why it is necessary to maximize synergies from Government and non-Government services in an integrated and cohesive manner. We also see the need to continue to improve coordination and cooperation beyond our borders. Thailand is currently providing HIV prevention, treatment and care for migrant workers from neighbouring countries with a substantial contribution from the Global Fund. We must now work harder and more closely with our fellow member countries of the Association of Southeast Asian Nations (ASEAN) to prepare for the ASEAN community that will emerge by 2015.

Last, but certainly not least, Thailand has scaled up treatment programmes that rely mostly on domestic funding and very little on international sources. In this respect, trade-related aspects of intellectual property rights (TRIPS) flexibilities have been and will continue to be an essential and vital contributing factor in our efforts to achieve universal access. From our

experience, it has become clear that TRIPS flexibilities help to ensure that people living with HIV around the world have access to care and treatment. This understanding is crucial if the international community is to fully achieve the goals of zero AIDS-related deaths and zero new infections. As both the Executive Director of the Joint United Nations Programme on HIV/AIDS and our Political Declaration (resolution 60/262) have spelled out, the international community as a whole must reach the global target of 15 million people living with HIV on antiretroviral treatment by 2015 if we are to be successful in our global response to HIV and AIDS.

Thailand reaffirms its continuing commitment to working closely with all nations to end the scourge of HIV/AIDS. Our long struggle has taught us many lessons that we would be pleased to share with others. Having set our sights on the three zeroes, we are now ready to walk the path ahead together with the international community to achieve the targets we have set not only for ourselves but for all people, no matter who or where they are.

The meeting rose at 6.10 p.m.